



THE SCOOP



2012
EDITION

Dearest Class of 2015,

We are extremely excited to be your new classmates and are delighted to welcome you to the CCRMC family. While your arrival is a heady time for us, it is probably even more so for you. All those things you've been told about the trials and growth you'll go through during Residency—well, they're true. But we also believe that training here is a singular experience and adventure that you will look back on with fondness and wonderment.

What you hold in your hand is a tradition started by the Residents of yore that we carry on today. It is not intended to be a repository of physicianship. You already have that in you. Consider this the CCRMC version of a Lonely Planet®, a guide meant to facilitate your desire to experience, grow, and learn.

Of course, don't forget that this guide is nothing compared to the resources that surround you: your fellow Residents, Attendings, Nurses and other Staff!

Happy Trails!

THE 2012 SCOOP TEAM

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M. Mennens
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A. S.

p.s. We welcome any feedback or suggestions you may have about this document. Please also store those thoughts in the back of your own mind—they will come in handy when you design next year's Scoop!

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Phone Numbers

Hospital - Main Line (925) 370-5200

Wards		Other Areas (Cont'd)	
3B - Emergency Dept	5973	Echo	4354
3D - ICU	5660	GI Lab	5358
3D - ICU Work Room	5676	Laboratory - General	5390
3E - IMCU	5666	Laboratory - Microbiology	4413
4A - Telemetry	5780	Laboratory - Public Health	5775
4B - Medical	5630	Medical Records	5207/5210
4B - Work Room	5634	MRI	4234/5320
4C - Psych Inpatient	5389	Nuclear Medicine	4158
5A - L&D	5608	OR	5340
5B - Post-Partum	5613	OR Scheduler	5645
5B - Nursery	5615	PACU	5349
5D - MedSurg	5650	Pathology	5400
5D - Work Room	5303	Pharmacy - Inpatient	5256/4017
Other Areas		Pharmacy - Outpatient	5245
Antepartum Testing (ATC)	5950	Pharmacy - Clinical Pharmacist	5668
Blood Bank	4414	Radiology - Ultrasound	5335
CT Tech	4324	Radiology - X-ray	5320
CT Radiologist	5808	Radiology - X-ray Tech	4833
EKG	5585	Radiology - File room	4828

Social Work & Discharge Planning

ICU & IMCU	Ext/Pgr	OB/Post-Partum	Ext/Pgr
Mary Roache	5491/228	Rita Barouch	5444/339
4A		Vicky Dominguez	5486/151
Marsha Krinsky	5587/390	Float	
4B		Felice Hoeft-Laden	5060/194
Rm 2-6: Marsha Krinsky	See 4A	Discharge Planning	
Rm 8-20: Rani Visweswaran	5487/774	IMCU/ICU: Mary Roache	5491/228
Rm 22-34:		4A & 5B: Remy	5647/985
5D		4B: Hillary	5308/442
Rm 14-20,24,30-34:		5D	5183/274
Okee Nwadigo	5489/432		
Rm 2-8,10-12,22,26,28:		Financial Planning	5570
Cynthia Fullwood-Fleck	5787/564		

Outside Numbers

Night Pharmacy	(866) 503-4443
Poison Control	(800) 222-1222
IT Help	(925) 957-7272
Transfer Centers	
UCSF	(415) 353-5166
UC Davis	(916) 734-8200
Stanford	(650) 723-4696
CA Pacific Med Ctr	(888) 637-2762

Residency Administration

Danielle Brodus-Zamora	4465
Tami Sloan	5045
JoAnn Valencia	5036

Important Numbers – CODES

Don't get locked out again!

- * For some of the key pads hit # after the code... If you flub and need to start over, hit '*'
- * General number to most doors, including 3rd floor call rooms = **2451(#) or Room Number SDRAWKCAB (BACKWARDS)**

Hospital Codes

Second Floor		Fourth Floor	
OR Stairwell	6330(#)	4A Conference Room	5444
OR Locker Area	94553	4B Doors	2500
Third Floor		Fifth Floor	
ER	1542(#)	Resident Lounge	5355
ER Break Room	5170	OB OR Suite	6315
ER Ambulance Door	5150	OB Call Room	9055
ER Supply Room	1414	Peds Office	6315
ICU	1133	Nursery	5615
IMCU	6318	5C Clean Utility	2451
IMCU Med Room	3135	Ground Floor	
Call Rooms	2451	Medical Records	6616
Psych ED (CSU)	5150(#), 77325, 2500	South Entrance	2451#

Building 1 & Campus

Building 1		Library	
General	6380	Front Door	2451(#)
Noon Conference	3344	Mailroom	2451
Miscellaneous			
Cafeteria	002451	Pathology Building	2451
Computer Lab	6555*		

Outlying Clinics

Pittsburg		Richmond	
My Clinic	_____	Clinic, Office Doors	4135
		Supply Rooms	20102

Important Numbers – RESIDENTS

	PGY-1	PAGER	CLINIC	EMAIL
PAGER PREFIXES	Ashley Ballard	942	PHC	aballard@ccfamilymed.com
(Inside CCRM):	Kimberly Butler	930		kbutler@ccfamilymed.com
555 - ***	Stephanie Cheng	947		scheng@ccfamilymed.com
(Outside CCRM):	L. Emily Cotter	946	RHC	ecotter@ccfamilymed.com
(925) 346 - 4***	Danielle Draper	996		ddraper@ccfamilymed.com
GROUP PAGERS	Stephen Merjavy	992		smerjavy@ccfamilymed.com
All Residents 179	J. Travis Nelson	975	NRHC	tnelson@ccfamilymed.com
Inpatient Residents 440	John Parr	953		jparr@ccfamilymed.com
FPC/TLC 600	David Piccinati	943	AHC	dpiccinati@ccfamilymed.com
PGY-1 890	Brent Porteous	957		bporteous@ccfamilymed.com
PGY-2 891	Mena Ramos	927	CHC	mramos@ccfamilymed.com
PGY-3 887	Erin Stratta	991	PHC	estratta@ccfamilymed.com
SERVICE PAGERS	Tina Toosky	984	RHC	ttoosky@ccfamilymed.com
House Officer 901	Lauren Wondolowski	941	PHC	lwondolowski@ccfamilymed.com
FMS/Admit 674				
	PGY-2	PAGER	CLINIC	EMAIL
TRAVIS RESIDENTS	Jon Froyd	857	CHC	jfroyd@ccfamilymed.com
Medicine 747	Christina Hamilton	865		chamilton@ccfamilymed.com
Nursery 907	Jessica Hamilton	258		jhamilton@ccfamilymed.com
EMAIL LISTS	Geena Jester	870		gjester@ccfamilymed.com
____@ccfamilymed.com	Abby Luensmann	840		aluensmann@ccfamilymed.com
All Residents	Joe Mega	842	RHC	jmega@ccfamilymed.com
residents@	Monika Mehrens	270	AHC	mmehrens@ccfamilymed.com
Class of 2013 (PGY-3)	Rohan Radhakrishna	207		rradhakrishna@ccfamilymed.com
class2013@	Jeana Radosevich	843		jradosevich@ccfamilymed.com
Class of 2014 (PGY-2)	Abby Rardin	876	PHC	arardin@ccfamilymed.com
class2014@	Jay Reinking	845	NRHC	jreinking@ccfamilymed.com
Class of 2015 (PGY-1)	Leah Schweid	846	PHC	lschweid@ccfamilymed.com
class2015@	James Walls	879	RHC	jwalls@ccfamilymed.com
Chief Residents	Courtney Wright	847		cwright@ccfamilymed.com
chiefs@				
Scheduler				
schedule@				
	PGY-3	PAGER	CLINIC	EMAIL
	Melina Beaton	580	NRHC	mbeaton@ccfamilymed.com
	Brea Bondi-Boyd	579	PHC	bbondiboyd@ccfamilymed.com
	David Carey	578		dcarey@ccfamilymed.com
† = Chief Resident	Ne Ferguson†	575		mferguson@ccfamilymed.com
‡ = Scheduling Chief	Kate Goheen	571	CHC	kgoheen@ccfamilymed.com
	Rita Hamad	570	RHC	rhamad@ccfamilymed.com
	Erin Helgersen	563		ehelgersen@ccfamilymed.com
	David Lee	562	AHC	davidlee@ccfamilymed.com
	Trang Lehman	856		tranglehman@ccfamilymed.com
	David Longstroth†	552		dlongstroth@ccfamilymed.com
	Michelle Robello‡	550	AHC	mrobello@ccfamilymed.com
	Lisa Rodelo	549		lrodelo@ccfamilymed.com
	Paul Shen	548	PHC	pshen@ccfamilymed.com
	Brent Sugimoto†	544	RHC	bsugimoto@ccfamilymed.com

Important Numbers – STAFF

Ahmed (Gero-psych) 402	Feirabend (OB) 415	Liebig (radiology) 495 ext 5336	Sobel (ER) 322
Applegate (ICU) 375	Fentress 199	Lockhart (OB) 970	Speech 553
Arpajirakul 323	Ferris (Inf Ctrl) 263	Loeliger (OB) 922	Stanger,Kali 324
Bader (ortho) 895	Fish 187	MacDonald (FMS) 368	Stone (rheum) 337
Bannwart (FMS) 759	Forman (GI/ICU) 365	Macedo (OB) 725	Stromberg (CHF) 410
Barrios (FMS) 320	Freedman (Med) 091	Mahar (cards) 597	Sullivan (Med) 554
Beach (FMS) 748	Graham (Med) 995	McCormick (hem/onc) 882	Sutherland (Med) 127
Beck (OB) 284	Gynn (Surg) 820	McIlroy 303	Thedinger (Med) 416
Berguer (Surg) 299	Haglund (FMS) 527	McNeil 306	Tornabene (Med) 751
Berletti (OB) 204	Hay (OB) 043	Moeller (FMS) 060	Tsang 326
Bhandari (Med) 057	Hennigan 504	Montandon 792	Tzvieli (Med) 321
Bhatt 521	Hiner (heme/onc) 223	Newfield (OB) 689	Urcuyo 329
Bliss (OB) 286	James (ortho) 506	Ortho tech (Pat) 582	
Brody (Med) 568	Johnson (Med) 589	Peds on call: 733	
Carey, Joe (FMS) 679	Katie (dietary) 100	Pham 314	
Cavallaro (OB) 156	Keller (OB) 705	Psych Consult 652	
Cheng, Siri 719	Kim (path) 328	Quiñones (FMS) 929	
Cominos (FMS) 177	Kleinerman (Uro) 573	Raphael (Surg) 584	
Curtis (FMS) 268 510-375-5352 (cell)	Kuruvilla (ICU) 598	Reif (GI) 517	
Dao (OB) 405	Lee, Becky (FMS) 250	Saffier 334	
Diaz (ICU) 331	Lee, Dan (FMS) 667	Safianoff (pulm) 233	
Dosanjh, A (plast) 154 (415) 309-5611 (cell)	Lee, John 226	Sandler (FMS) 229	
Echols (Psych) 643	Lehman, Tara (OB) 707	Schaplow (FMS) 358	
Emily (dietary) 313	Levin (Med) 784	Sinha (ortho) 835	

Dictations

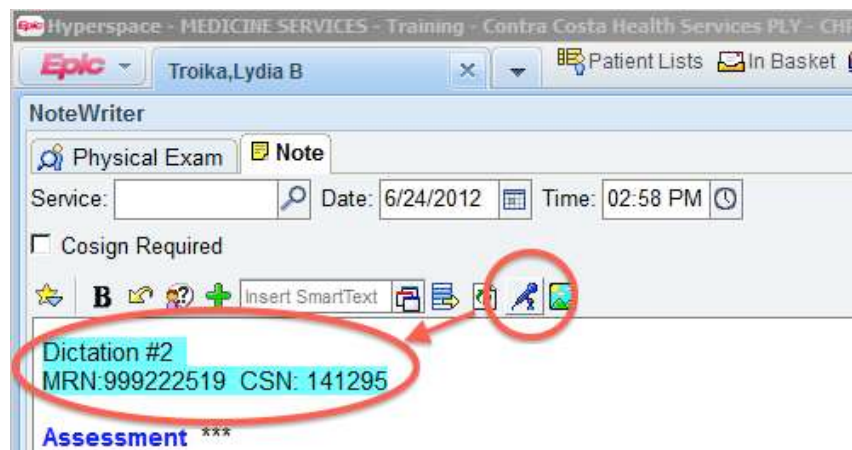
As CCRMC transitions to ccLink, dictations will largely become unnecessary and even discouraged, as they do not take advantage of ccLink's functionality. However, there may be some instances, where you may find yourself wanting to dictate.

DICTATION INSTRUCTIONS:

1. Place cursor in the desire place in your note and press the microphone. Note the **Dictation Number**, **MRN**, and **CSN** (See Figure Below).
2. Press 77 from any hospital phone (6-9305 from outlying clinics)
3. Enter your Physician ID number followed by '#'
4. Enter Number for location (1 for Martinez, 2 for Richmond, etc.) and '#'

Dictation HOT Keys		Code	Dictation Type	Code	Dictation Type
1	Pause	1	ER report	12	Transfer Summary
2	► Resume	2	Specialty note	13	Off Service Progress Note
3	◀◀ Rewind	3	Operative report	15	In-patient note
5	■ End	4	H&P	20	Death summary
#	↵ Enter	7	Discharge summary	21	Procedure note
*	STAT (~ 2 hours)	8	FP note	22	Delivery note
		9	Consult	34	Stat transfer summary
		10	Correspondence	35	OB Triage
		11	Resident ER report		

5. Enter number corresponding to type of dictation and '#':
6. Enter patient's Medical Record Number followed by #.
7. Dictate note. Be sure to include **Dictation Number**, **MRN**, **CSN number** in your dictation. This is the reference key that will match your dictation with the correct patient's note (See Figure below).
8. At end of dictation state "End dictation." Then press 5. The system will state the dictation number. Type this number your note as proof that it was dictated.



qPatient qDay

Signout saves lives. It is a Joint Commission requirement that we sign out to each other. It is also extremely helpful to the House Officer who takes care of your patients through the night. ccLink gives us a new tool to communicate with each other more efficiently and effectively, however, remember that while ccLink is a tool to facilitate communication, *it is a Joint Commission requirement that sign out is relayed verbally, so that the recipient has the chance to ASK QUESTIONS.*

The Verbal Process

1. The departing resident will enter any to-do items into ccLink (see below).
2. The House Officer (HO) will not get admits for at least the first 30 minutes of their shift at 5pm, but focusing the HO's attention on signout until adequate signout has been achieved is the ultimate goal
3. The departing resident will sit down with the HO while the HO "drives" the computer within ccLink. If a departing resident is in clinic, the resident should page the HO to discuss any to-do items and briefly go over the resident's patient list.
4. The departing resident should QUICKLY give one-liners on patients and clearly describe "nothing to do" versus "you have to do this..." If patients are known to the HO, saying "nothing new on anyone and nothing to do" is OK, as long as the HO can ask questions of the departing resident. An example is "45 yo with CHF, diuresing, nothing to do, next patient..."
5. If the departing resident does not make contact by 6 pm, the HO contacts the team's attending for sign out (n.b., contact means just that and is not restricted to sign out — it could be "I'm still in clinic; I'll call you by 7 o'clock to sign out."). The pediatric attending should contact the HO to give signout for nursery patients.

The ccLink process

1. The departing resident should have entered any to-do items or specific instructions in the "MEDICINE SIGN-OFF" field within ccLink (Figure 1).
2. The HO will create a new list in ccLink (example has been entitled "HO Signout") and insert whatever columns into this

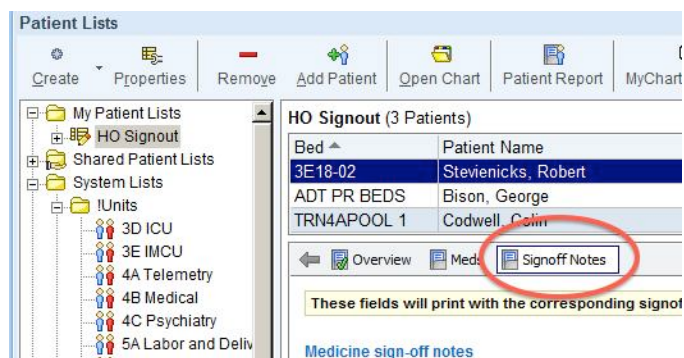


Figure 1. Add 'active' patients to HO Signout List

Signout (cont'd)

- list desired (reference ccLink inpatient training guide for tips on this part) (Figure 2).
3. The HO will drag patients from other lists into this list as they get specific to-do items – this will allow the HO to TRACK all active patients that they need to address overnight
4. The HO may use whatever paper methods (s)he prefers to augment this process, but keeping a list of active to-do items will be important in case the paper method fails (*i.e.*, gets lost).
5. The HO may print out a “Patient Report” of “Medicine Signoff” items if they wish of all patients within a specific list
 - a. This is NOT recommended for the entire hospital because the list generated takes about 2 patients per page (40 pages for just med-surg patients) (see image 3)
 - b. This might be more practical for the ICU resident to print if they want something in their pocket
 - c. MOST IMPORTANTLY, the second something is printed it technically is obsolete data – the whole purpose of an EMR is to have up-to-date information at your fingertips. Remember this when considering printing anything.

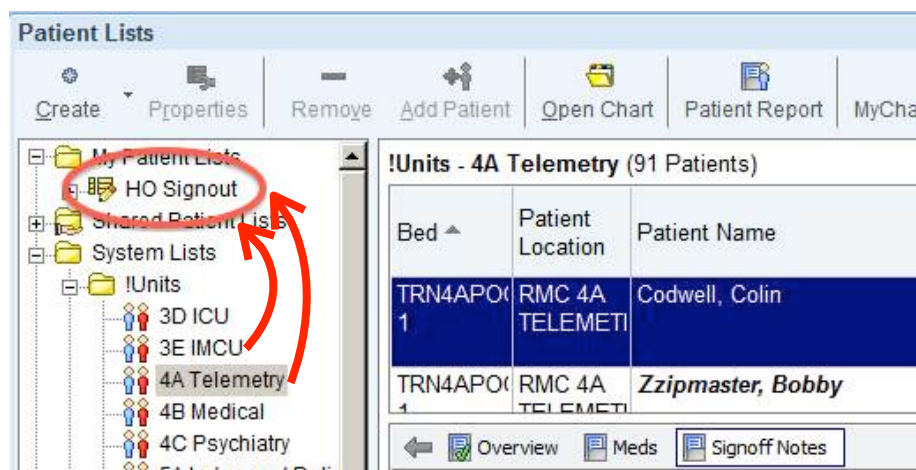


Figure 2. Add 'active' patients to HO Signout List

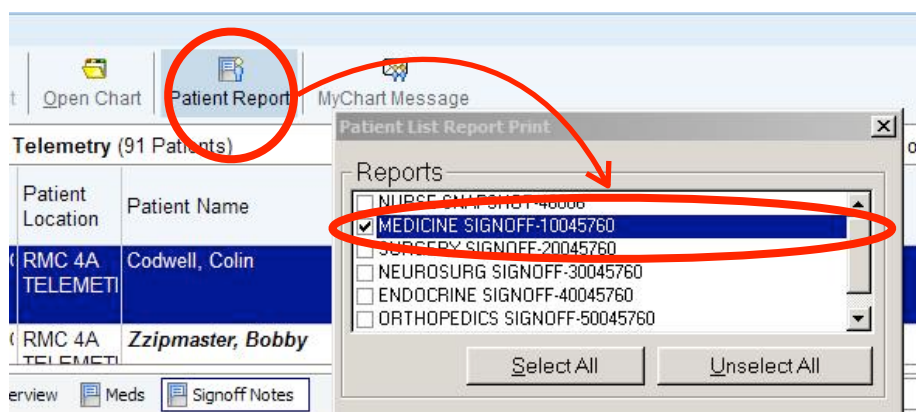


Figure 3. Print out Signoff Report as needed

Hospital Admissions

GUIDELINES

Your pager rings '5973'. This means you got an admission! You should call back as soon as possible to talk to the admitting ED Physician and then go to assess the patient quickly (whether or not you start the admission). **Resident are expected to assess (not necessarily admit) the patient within 30 minutes.** Make your own evaluation of the patient's level of care — if you believe the patient may be at a higher level of acuity, do not hesitate to discuss this with an attending or senior resident.

Holding Orders

Because of the high volume of patients seen in the ED, the ED physician may want to move the patient to the floor before you finish the admission. As of March 30, 2012, to improve patient safety, no patient may be sent to the floor with holding orders without the consent of either the ICU or admitting resident, or the attending physician on call. There have been cases of patients being inappropriately sent with holding orders to a lower level of care than was needed. Please discuss this with your attending, and/or Drs. Sara Levin and Kristin Moeller, if patient are being sent with holding orders without your or someone else's consent.

Admission Staffing

- All admissions performed by an Intern must be presented to either a Senior Resident or Attending.
- **Family Medicine Service:** All patients are presented to FMS registrar on call.
- **Medicine:** Patients to the general medical floor (e.g., Ward 4B) may be presented to a senior resident. All others (IMCU/ICU/Telemetry (4A)) must be presented to an attending
- **Labor & Delivery:** All admissions to L&D are presented to the attending on call. All triages (even non-admitted) must also be presented.

Medication Reconciliation

This is an area of frequent errors that can jeopardize patient safety. The ED Nurse is supposed to be in charge of inputting patient medications into the system, but you must also verify them yourself.

Orders

Once the admission has been completed and all orders have been written, **SIGN AND HOLD THE ORDERS**, which allows the nurse to release your orders to carry out your plan of care. **DO NOT 'PEND' THE ORDERS**, as nurses cannot release them. Pending orders are incomplete and mean that you intend to finish them at another time.

GUIDELINES

Most patients admitted to the hospital need a discharge summary on discharge (exceptions are post-partum patients and neonates without complications whose stay is less than 72 hours).

The discharge summary should give an idea of why the patient was admitted, what happened during the hospitalization, the conclusions made, and ideas for follow up and future management. Be succinct and explain the thoughts underlying the patient's care. No one wants to read a five page play-by-play of the admission. However, we do want the pertinent information and to understand why you did what you did and how you came to your conclusions.

Medications MUST be included in your discharge summary. Think about what you would need to care for the patient in the clinic, or on a subsequent ER visit.

A list of pre-hospital medications can be very helpful. One way to do this is 3 sections:

1. Pre-hospital medications,
2. Medications discontinued while in-house,
3. Final discharge medications

Follow-up

If you feel the patient is at high risk for readmission, consider scheduling a home visit. You can page Dr. Lynn Stromberg (pager 410) to arrange home follow-up, especially for those who congestive heart failure (CHF), poor health literacy with complex medical problems, and the elderly. Patients at skilled nursing facilities (SNF's) are not appropriate patients for Dr. Stromberg. For CHF patients, be sure to include the discharge weight (or dry weight) in your discharge summary.

For CHF patients close to discharge, consider paging the CHF nurse to arrange interdisciplinary rounds with the patient (pager 639) to help the patient understand the plan for care. Be sure to page the CHF nurse several days before discharge to arrange CHF rounds.

Uninsured Patients

Occasionally we will get uninsured patients who do not qualify for the County Health Plan or MediCal (especially undocumented patients), and therefore have no coverage for follow-up or medications. Please be sure to discharge these patients with medications that they can afford. This may mean choosing unusual medication regimens, or less than ideal choices that are nonetheless better than no medications at all. The Walmart and Target \$4 lists can be accessed both from their pharmacy websites as well as the Epocrates drug formularies. Patients can also utilize CostCo Pharmacy (whose prices are often less than Walgreens) even if they are not members.

Hospital Transfers

1. Once you have decided that you need to transfer your patient to another hospital for services we do not provide, contact the discharge planner, who can assist you with identifying possible accepting hospitals based on patient insurance, as well as assisting with contact information
 2. Call the Transfer Center and tell them you have a patient you would like to transfer. That person (typically a nurse) will walk you through the information they need. If (s)he decides they can accept, you will be given the physician contact information for clinician acceptance
 3. Contact the accepting physician. Lead with the reason for your transfer and what service the patient needs (e.g., I have a 65 year-old poorly controlled diabetic with uremia who I need to transfer for dialysis). The accepting physician usually will ask for the information (s)he wants.
 4. Once you get acceptance, notify the discharge planner, who will arrange for transport as well as a pile of paperwork for you to complete.
 5. You will need to complete all patient paperwork including transfer summary and medication reconciliation. If you choose to dictate, you must choose dictation type "34 - Stat Transfer Summary." Social work usually will gather images, diagnostic reports for transport, but it may be good to verify this.
- ★ **Cardiology:** If your patient has MediCal, call **East Bay Cardiology at (510) 233-9300** (affiliated with Doctor's Medical Center). If your patient has another type of health insurance, it depends on where they live. For West County residents, call East Bay Cardiology. For East or Central County residents, consult **Contra Costa Cardiology at (925) 671-0610** (affiliated with John Muir).

Transfer Centers	
CA Pacific Medical Center	(888) 637-2762
Doctor's Medical Center (Ask for Nursing Supervisor)	(510) 970-5000
John Muir Medical Center - Concord (Ask for Nursing Supervisor)	(925) 682-8200
Stanford University	(650) 723-4696
UCSF	(415) 353-5166
UC Davis	(916) 734-8200

Deaths

Although often the patient's nurse has already made the determination that the patient has died, a physician must make the official pronouncement. California Health and Safety Code Sections 7180 and 7181 establish two methods of pronouncing death:

- Determine that there has been irreversible cessation of circulatory and respiratory functions. Generally this condition is satisfied when no heart beat or breath sounds are heard after approximately sixty (60) seconds of auscultation.
- Two physicians determine that brain death has occurred. In this case, the official time of death is the time that the second physician confirms brain death. This generally will not need to be done on the floor.
- Note the **Time of Death**
- A **Death Note** must be entered in the chart
- Nursing will give you paperwork to complete
- As a courtesy to the primary team, the Night House Officer may complete the discharge documentation, although this is not an expectation
- In almost every case in the hospital, **the coroner does NOT need to be contacted**. Reasons for contacting the coroner include undetermined cause of death; death that took place outside of medical care; suspected suicide; injury or accident; death caused by crime.

If family is present at an expected death, offer condolences and ask if they have any questions. If they have a funeral home chosen, they need to sign the official paperwork to give permission to release the body. In any unexpected or not-straightforward death, offer an autopsy to the family (e.g., in a scenario of an unexpected code blue).

If family is absent, discuss with the nursing supervisor or charge nurse how long the patient can be held in his or her bed until the family can arrive. Call the primary family member and inform of a "change in status." Ask if they can come to the hospital. You can say that the condition is "critical." This is done primarily for safety reasons with driving. If they ask if the patient has expired, you can say yes.

You may ALWAYS ask for the assistance of other residents/attendings in speaking with family members if you would be more comfortable. If family is sounds distraught on the telephone, consider asking if they can have a friend or neighbor drive.

Note: All intubations and lines must be left in place for an autopsy and family should be forewarned of tubing, etc., before entering the room. If they do want an autopsy, the next of kin must sign the official paperwork. If they decline, have nursing staff prepare the patient for the family.

General Advice

1. When in doubt, ask the ICU resident.
They are there to help, teach, and back you up when you need it. Also, the ER doctors are knowledgeable and always willing to give you advice. Finally, the on-call registrars are getting paid to back us up – call them if needed. The bottom line is, you are not alone!
2. Your job is not to solve all of the patient's problems overnight.
Sometimes you have to gently set expectations of nurses, patients, and patient's families regarding what your role is when you are covering for an entire hospital full of patients.
3. You have a ton of responsibilities when you are on call, do your best to triage – it will get easier over time.
Here is your list of included expectations as house officer:
 - a. Crosscover nursery, all of the 4th and 5th floor (excluding OB/Post partum)
 - b. Neonatal resuscitation for OB response calls (stat C-sections)
 - c. Admissions
 - d. Assisting the surgeon for overnight cases
 - e. Procedures (per resident preference)

COCKTAILS

Everyone's favorite, especially on call

Haldol Cocktail: *Caution in the elderly or demented.* For the agitated patient. Haldol 5 mg IM + Ativan 2 mg IV/IM + Diphenhydramine 25 mg IV/IM (or Cogentin 1 mg IV/IM). Diphenhydramine/Cogentin protect against the extrapyramidal effects of Haldol.

GI Cocktail: For the patient whose stomach pain is keeping him/her and you awake at night... Be sure the pain is GI and not cardiac before giving! Maalox 30

mL + Viscous lidocaine 10 mL ± Donnatal 10 mL

Banana Bag: For the patient whose had too many cocktails... Prevent Wernicke-Korsakoff: In 1 L NS, add Thiamine 100 mg + 1 mg Folic acid, Multivitamin 1 amp, MgSO₄ 3 grams.

Unclogging a G-tube: Unclog with 2 tablets pancrelipase (Viokase) and 1 tablet bicarbonate (650 mg), crushed in 5 to 15 mL of lukewarm water. Run through the G-tube.

Unclotting a PICC: Alteplase 2mg

PAIN MEDICATION

Pain medication is likely the most common call... and, sometimes, the most challenging.

First ask the nurse what the patient is getting and what their assessment of the patient's pain level is. Is this drug-seeking behavior? Or is this a patient who really is in pain? Is it pain you would expect or does it need to be worked up? Writing a one time order and having the primary team reassess in the morning is usually okay – you don't know the patient like they do. Also make sure that there is not an anxiety component – offer benzos if so... You can give a one time order over the phone but for most narcotic standing orders you need to fill out the high-potency order set. Writing "hold for sedation" is always a good idea for patient safety.

Mild pain:

Tylenol 650mg PO/PR Q6 (max daily dose 3gm or in liver dysfunction 2000mg/day)

Ibuprofen (600 mg q6-8 hours) – not for pre/post-op pts with bleed risk or renal problems

Moderate pain:

Vicodin or Percocet 1-2 tabs q4hours

PRN, not to exceed 3 g in a 24 hour Tylenol dose.

Toradol 30 mg IV x 1 (up to q6h x 5 days), is an effective non-narcotic injectable, but not in patients with bleed risk, peptic ulcers, cirrhosis, renal disease or CAD. Check creatinine first.

Severe pain: Try to leave this up to the primary team if possible

Morphine 1-2 mg IV is a good place to start in a patient that you don't know. If considering a PCA pump, go with the "usual starting dose". Avoid using a basal rate whenever possible. Sometimes using multiple agents is the best approach... i.e., NSAID and opioid

Here is a brief conversion list – Use it wisely!

1 tab Vicodin (5 mg HYDROcodone/500 mg Tylenol) = 1 tab Norco (5 mg HYDROcodone/325 mg Tylenol) - Norco is NOT on the inpatient formulary

1 tab Percocet (5 mg OXYcodone/325 mg Tylenol) = 1.5 tab Vicodin (5/500)

5 mg PO morphine = 1 tab Vicodin (5/500)

3 mg PO morphine = 1 mg IV morphine

4 mg PO Dilaudid (HYDROMorphine) = 1 mg IV Dilaudid (HYDROMorphine)

1 mg IV morphine = 0.01 mg (10 mcg) IV Fentanyl

7 mg IV morphine = 1 mg IV Dilaudid (HYDROMorphine)

Methadone is VERY long acting and shouldn't be changed unless you know what you are doing - it is beyond the scope of The Scoop.

Opiates are constipating – "the same hand that writes for opiates writes for DSS"

FREQUENT FLOOR CALLS

CHEST PAIN

1. Go Evaluate the patient

2. STAT EKG
3. Oxygen
4. Chew 325 mg ASA
5. SL nitro 0.4 mg q 5 min x 3
6. 2 mg morphine for pain
7. If you suspect cardiac ischemia, call ICU resident to transfer patient to a monitored bed and order cardiac enzymes.

Numbers 1-3 are usually done regardless of what your suspicion is for etiology of the chest pain. If it's a patient on 4A you may want to go ahead and order the NTG while on the phone... then go assess the patient.

Consider repeat EKG if suspicious of ischemic etiology, call ICU resident PRN. Remember to look at old EKGs for comparison.

RESPIRATORY DISTRESS:

Go assess the patient! Your assessment of lung sounds may be very different than the nurse's. What's the etiology? Asthma? CHF? Pneumonia? PE? Oversedation?

You can always call RT... they are great about giving good advice (Nebs, BiPAP, etc.)

If you're concerned about worsening CHF... CXR and lasix

If CO2 retainer... be very careful when administering O2

If anxiety... anxiolytics (ativan)

If oversedation...consider narcan

ALWAYS CONSIDER GETTING AN ABG! IT OFTEN CLARIFIES THE PICTURE!

AGITATION/ANXIETY:

Use caution using anti-cholinergics

(benadryl) or benzos in the elderly/
demented/delirious

Why is the patient agitated – sometimes it's a symptom... under-medicated for pain? Demented? Sundowning? Drug-seeking? Over medicated? Anxiety? Withdrawing? Air-hunger?

Go visit the patient to evaluate the situation if you have not seen the patient previously.

First try talking to the patient, and encourage the nurses to try re-directing – it works!

Sometimes benadryl 25mg IV/PO may suffice for sedation, you can also offer temazepam 15mg

Ativan 1-2 mg IV/PO q 2-6 hours PRN will do the trick (0.5 mg in frail/elderly)

However, benzos can actually worsen delirium in the elderly... Strongly consider haldol for these patients.

Haldol 1-2.5 mg PO/IM q 4 PRN... is a good start. If patient is still agitated you can increase dose and frequency (IV not available unless in ICU/IMCU). Check the QT_c for standing orders.

BLEEDING:

Assess patient... is it severe or just post-operative oozing? Stat CBC if anything more than a small ooze, consider checking coags.

Check vitals and consider IVF... if hemodynamically unstable... LR wide-open and call ICU resident/registrar PRN.

If severe or baseline Hgb is already on the low side <7-8, type and cross match several units of blood - call ICU resident/registrar PRN.

Nurses will call you about platelets: OK to give heparin or lovenox if platelets

>50,000

BLOOD PRESSURE:

HIGH: Is the patient in pain? Anxious? These are the most common, treat them first.

Was the patient on meds as an outpatient that were not started or the wrong dose was started?

Go with shorter acting medicines. (NTG paste ½ inch to chest q6, clonidine 0.1BID, captopril 12.5 po TID, hydralazine 10mg PO Q6 - All can be used PRN SBP>160-180.)

What's the patient's HR? Can they tolerate a beta-blocker? 25 mg metoprolol? 30 mg diltiazem? Or nitropaste? This can be applied and quickly wiped off if BP falls to low.

LOW: Dehydration? Ask about urine output (think about checking urine lytes/spec grav)...

Trying a little fluid bolus and seeing if the patient responds is usually a good start

NS 250 mL or NS 500 mL (more caution if NO urine output or CHF)

Med Check... is the patient on a bunch of blood pressure meds?

If really low... Trendelenberg and ephedrine with likely transfer to the ICU for pressors.

CHEMSTICKS/INSULIN: "THE PATIENT'S SUGAR IS..."

Part of the sliding scale insulin order says "call HO if sugar is over..." Usually this is not a big deal... patients often run high while hospitalized, especially when they're on steroids.

Ask what the highest step is on their

sliding scale insulin and give that, or that + 2 units. Ask them to recheck in 2 hours and to give you a call... this is just so you know that the glucose level is going down... Don't give extra insulin at the 2 hour re-check, because it takes 3 hours for the prior regular insulin dose to take full effect.

If the glucose is sky-high (>500) and not responding you may consider checking a basic panel to evaluate bicarb/anion gap and r/o DKA. If they are in DKA they'll need to be transferred to the ICU for an insulin drip. If the patient is consistently high you may need to bump them up to a higher level on the SSI order.

FEVER

Fevers tell us something: Did they have it before? Should you watch the fever curve? Post-op?

If the fever is greater than 101.5°F you usually want to get blood cultures... check first if the patient has already had multiple sets of blood cultures, they probably don't need any additional ones.

Don't sweat a fever in a patient with a known source who has been cultured and has only been on antibiotics a day or two (unless it's really high or in a really sick patient). The nurse is required to call you but usually nothing needs to be done unless other vitals are concerning.

If the temperature is in a patient not on antibiotics, the patient is neutropenic, or spiking through the Tylenol you should probably examine the patient and consider changing/adding antibiotics and/or culturing urine/sputum, getting a CXR to evaluate for a source (BUT NEVER START ANTIBIOTICS UNTIL YOU'VE GOTTEN YOUR BLOOD CULTURES!

We've all made this mistake and kicked ourselves for it after the fact)

INSOMNIA:

****Use with caution in the elderly!****

Temazepam (Restoril) 15 mg PO x 1, may repeat in 45 minutes if insomnia persists OR

Benadryl 25-50 mg PO/IV x 1 OR

Trazodone 50-100 mg PO x 1, give with carbohydrate snack

Zolpidem (Ambien) 5-10 mg PO x1 (elderly or hepatic impairment may consider 5mg)

ITCHING:

Benadryl 25-50 mg PO/IV q6-8 PRN OR

Atarax 25-50 mg (max 100mg) PO q6-8 PRN

INTRAVENOUS FLUIDS:

LR or 1/2NS at 125mL/hour is always a safe bet... careful in little old people or CHF (go a little slower – like 75mL/hr).

For diabetics, add dextrose once blood sugar is < 150.

For rate, think the 4-2-1 rule (4 mL/hr for the first 10 kg weight, 2 mL/hr for the next 10 kg weight, and then 1 mL/hr for each subsequent kg).

If you're trying to rehydrate/bolus someone, NS or LR 500mL-1000 mL

Check latest potassium, if low, add 20mEq KCl per liter IVF

CONSTIPATION:

Docusate 250mg PO BID

Miralax 17gm daily

MOM 5mL QID PRN

Lactulose 15-30mL up to three times daily

NAUSEA

Ondansatron 4mg IV q6h PRN

Phenergan (promethazine) 12.5mg or 25mg TD or IV q6h PRN

Reglan (metoclopramide) 10mg up to QID

Compazine (prochlorperazine) 5-10mg TID

ELECTROLYTES

First, why they are abnormal: Not enough? Too much? Renal failure? DKA? Low Mg?

Hyperkalemia (EKG!): Kayexalate 15gm 1-4x daily

K scary high: Calcium gluconate, insulin w/ glucose, albuterol, sodium bicarbonate

“THE FAMILY/PATIENT WANTS TO TALK TO A DOCTOR...”

Yeah, that’s you! This usually means that the nurses have already exhausted their own resources to explain things. Or, there is a conflict between the nurse and the patient, and you get to be the intermediary. This puts you into a bad situation... you know virtually nothing about the patient/situation and you’re supposed to make it better. YIKES! And, to top it all off, you have two admissions waiting in the ED, a patient with CP on 4A and it’s 3:30 a.m. The main thing is to stay calm and think of yourself as the calming/reassuring presence in the situation. Read a little from the chart and learn from the nurse what exactly has happened before you were called and what the patient/family expects from you. Then go talk with the family or patient. Emphasize that you want to help, remind them that you are not the primary doctor so you may not be able to answer all of their questions, but do your best to answer what you can. Usually these situations turn out fine... the family/patient

appreciates seeing “a doctor” and you can tide them over until the morning when the primary team is available.

YOU DID AN LP, PARACENTESIS, THORACENTESIS... NOW WHAT?

Lumbar Puncture: Check an opening pressure if you can (pt must be on their side to be accurate)

Send CSF for Cell count with differential, total protein, glucose, gram stain, cultures

Thoracentesis: Get a pH first by sending fluid in an ABG tube on ICE to RT STAT (have the nurse with you at the bedside to bring the specimen down)

In the tubes provided: Cell count, gram stain and culture, total protein, PH, LDH, glucose (you also need serum LDH and glucose for Light’s criteria)

Consider: cytology (if cancer is in your differential), AFB, fungal cultures, rheumatoid factor, ANA, amylase (looking for pancreatic or esophageal rupture), triglycerides (>110 = chylothorax)

Paracentesis: Send for cell count, differential, gram stain, protein, culture, albumin and cytology (if suspect cancer). You will also need a serum albumin to calculate your SAAG.

IMPORTANT You need to send ascitic fluid for culture but there is a much, much higher yield if you inoculate the bottles at the bedside. To do this, get a blood culture bottle when you set up and, after drawing off some ascitic fluid, inject it directly into the bottle and fill to the line.

Soaked Dressings

Post-op patients often have drainage from their wounds. The nurses will call you if they find a dressing is saturated. This is something you should always go look at. You can do some triaging over the phone by asking for vitals. If hypotensive/tachycardic, you know you need to get there faster. Things that should worry you:

- Frank bleeding from a wound or coming out of a drain (JP or Blake drain)
- Hemodynamic instability
- Bleeding from an unidentifiable location, i.e. from inside the abdomen.

Things you can do:

- If grossly unstable, remember ABC's (CAB's): confirm IV access, fluids, order type and cross to transfuse blood, consider FFP, platelets etc, transfer to ICU (consult with ICU resident or attending/surgeon on call)
- If stable but concerning, check serial CBC's to follow hemoglobin, more frequent vitals
- Pressure dressing, cautery (in equipment cart on the floor)
- If very slow oozing (most commonly the case), just reinforce the dressing with more gauze

NGT/Dobhoff placement confirmation

Nurses can place NG and Dobhoff tubes but MDs confirm position. You may be asked to confirm placement before they can be used to give meds, tube feeds, etc.

Dobhoff: tip should be in duodenum, as it is often used for tube feeds. Confirm by

making sure you see it cross the midline on X-ray

NG tube: tip should be in stomach, confirm by making sure it goes below diaphragm. It may also curve around the stomach and can cross the midline a little

NGT clamp trials/residuals

When you think you are starting to have return of bowel function, gastric secretions will go downward as nature intended, instead of sitting in the stomach waiting to be sucked out by the NG tube. To prove to yourself that this is happening, and that it is safe to remove the NG tube, you can do a clamp trial. This involves clamping the tube for 4-6 hours, then hooking it back up to suction to see how much fluid is left in the stomach (the "residual" fluid). Each surgeon has a different definition of "passing" the trial.

- Weiss: 150ml after 3 hours
- Gynn: 200ml after 4 hours

If the residual fluid is less than the defined amount, you can remove the NG tube, and will likely see enough return of bowel function to avoid further need for an NG.

Post-Op Fever

Immediate (within hours of surgery): meds or blood products given during procedure, trauma prior to or as part of surgery, infection present before surgery, malignant hyperthermia (rare), atelectasis (debated)

Acute (within first week post-op): nosocomial infections

- Surgical site infection (SSI), specific to abd surgeries: deep abd abscess
- Pneumonia: risk factors include atelectasis, poor lung expansion

due to pain, altered mental status or NG tube increasing risk for aspiration

- UTI: risk factors include Foley catheters, urinary retention, GU procedures

Subacute (1-4 weeks post-op): central line infections, C.diff, drug reactions (antibiotics), thrombophlebitis, DVT, PE.

Keep in mind that the most likely flora involved changes as the patient is hospitalized longer and exposed to more antibiotics.

“My patient hasn’t peed in ____ hours”

Post-op patients can have urinary retention related to anesthesia. Urine output can also be a marker of hydration status, renal function, and tissue perfusion. In most post-op patients, options include:

- Fluid bolus if other signs of dehydration (tachycardia with hypotension)
- Wait a little bit longer.
- Ask the nurse to insert a Foley, and if she gets >300ml out, leave it in place.

“My patient hasn’t pooped in ____ days”

Post-op patients (especially post-abdominal surgery patients) often have this problem. While the pain meds they get post-op can be constipating, other more dangerous things should be high on your differential, especially if they have abdominal pain or distention—namely ileus or bowel obstruction. Options:

- Reverse diet or make NPO
- Abdominal series, or KUB with upright and supine views: this will show bowel distension, air-fluid levels, etc. It can be hard to tell

the difference between SBO and ileus with one film, but it can tell you GI function isn’t normal.

- If you see distention on the abd series, or if the patient has a lot of pain, you can place an NG (naso-gastric) tube to drain whatever is in the stomach. This can alleviate the distention, pressure, and pain.

Ulcer Staging

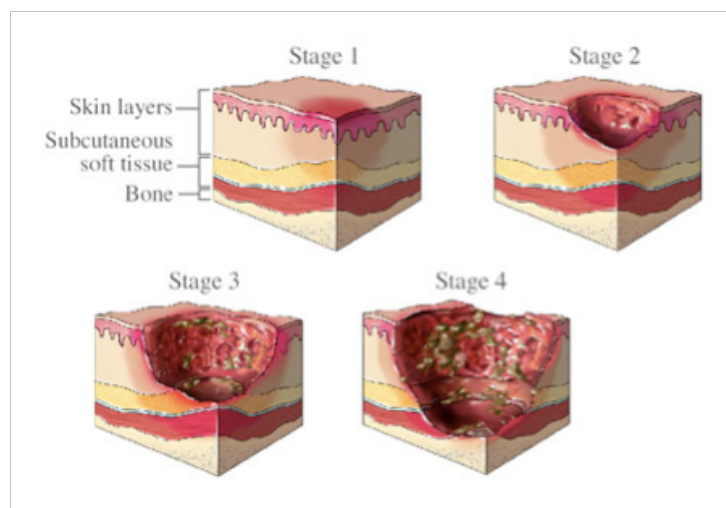
It is important to document ulcers, both new and pre-existing, and the initial documentation has to involve an MD.

Stage 1: Intact skin with nonblanchable redness of a localized area usually over a bony prominence

Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough

Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible, but not bone, tendon or muscle

Stage 4: Full thickness skin loss with exposed bone, tendon or muscle.



** If you get paged about a C-section or an OB response team is called, you're expected to go. Yes, we know that the floor is busy and there are always ER admissions to do, but admissions shouldn't come before C-sections. As long as the patient in the ER is stable, it's okay to go up to the nursery and then come back and finish the admission.**

As far as other calls, most of you will handle nursery calls before you do nursery. Generally speaking, have a very low threshold to call the pediatrician. Unless you totally feel comfortable with the order you are giving the nurse, call the pediatrician (pager 733) to run the question by them. Avoid just telling the nurse to call the pediatrician. You'll learn a ton more if you try to come up with a plan, assess the baby if needed, and then call the pediatrician yourself.

We have 2 levels of nursery at CCRMC. Level 1 (the opposite of trauma center designations) is baby at mom's bedside (most of our patients). Level 2 is the nursery. Babies go to the nursery if there are any concerning issues, risk factors, etc. We do NOT have a level 3 nursery (NICU), so babies will get transferred to CHO if they need that level of care.

JAUNDICE (THE MOST COMMON CALL, BY FAR)

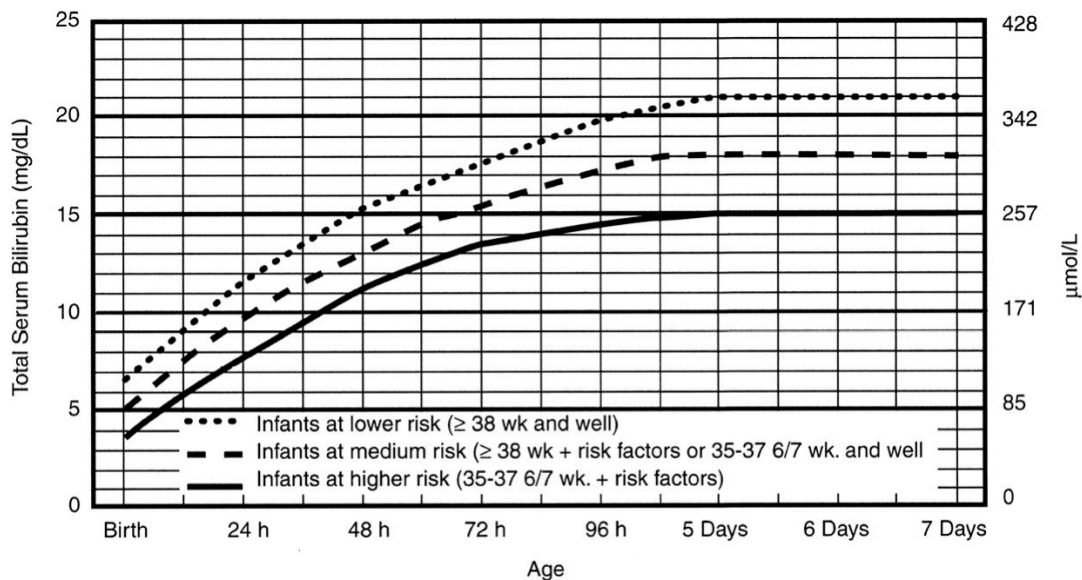
"Doctor, Babyboy Smith has a bilirubin of 14. What do you want to do?"

1. Is it a **manual** ("skin") bilirubin or a **serum** bilirubin measurement?
 - a. You want a serum level.
2. Is the bilirubin level direct or indirect?
 - a. The first time a bilirubin is drawn you should make sure there is a direct and total

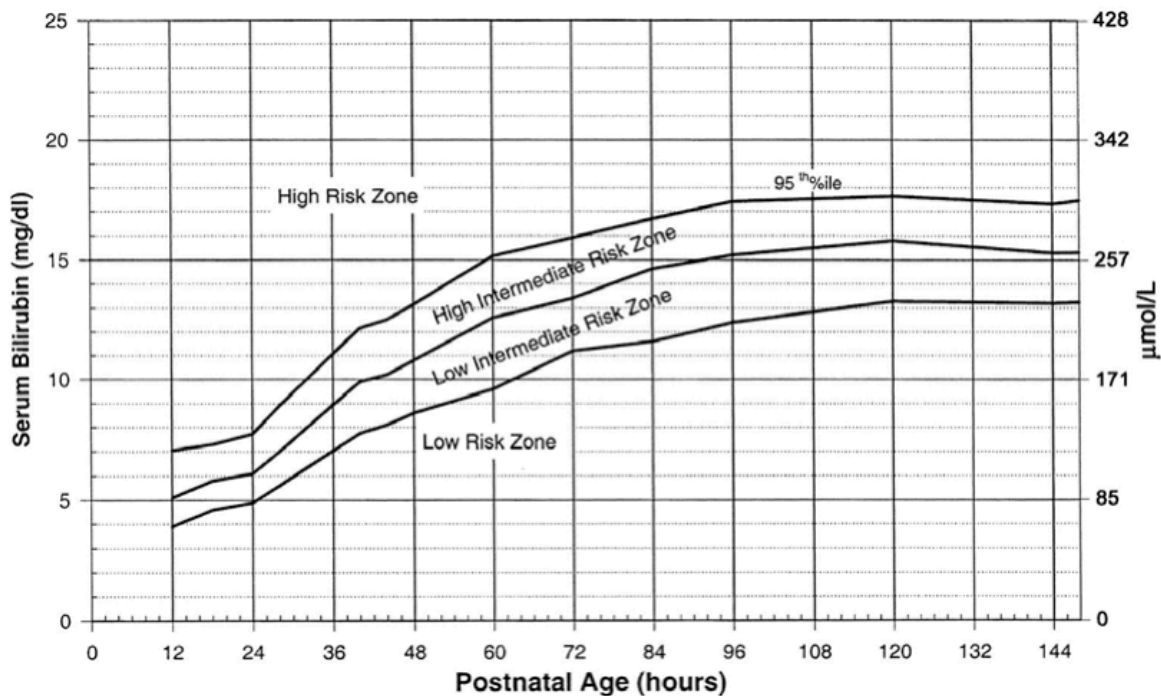
bilirubin to know that you are not missing hepatobiliary diseases. (Many times the direct bili is flagged as high – check to see if it's over 20% of total bilirubin).

- b. Subsequent bilirubin levels can just be total bilirubin.
3. How many hours old is the infant
 - a. The hours-age of the child determines the threshold for treatment (see phototherapy chart).
4. Is the infant pre-term?
 - a. Pre-term infants younger than 35 weeks use a different chart that is NOT in this booklet.
 - b. Call the peds attending on call.
5. Treatment
 - a. Look at the bilirubin chart below for treatment
 - b. Ask the nurse if there are any of listed risk factors and plot accordingly.
 - c. Any bilirubin level above the appropriate line means the baby gets phototherapy and a serum re-check in the morning. Call the peds attending on call and let them know.
 - d. It is important to remember that the guidelines are to be followed fairly strictly. Don't be the one to go outside of the guidelines, let the peds attending do that if they wish.
 - e. If you are below the appropriate line, order a re-check for the morning. If you are anywhere close to the line, order a serum bili for the morning. Otherwise, a manual might be ok per your discretion.

Remember Bilitool.org if you find it hard to



- Use total bilirubin. Do not subtract direct reacting or conjugated bilirubin.
- Risk factors = isoimmune hemolytic disease, G6PD deficiency, asphyxia, significant lethargy, temperature instability, sepsis, acidosis, or albumin $< 3.0\text{g/dL}$ (if measured)
- For well infants 35-37 6/7 wk can adjust TSB levels for intervention around the medium risk line. It is an option to intervene at lower TSB levels for infants closer to 35 wks and at higher TSB levels for those closer to 37 6/7 wk.
- It is an option to provide conventional phototherapy in hospital or at home at TSB levels 2-3 mg/dL (35-50mmol/L) below those shown but home phototherapy should not be used in any infant with risk factors.



see the little lines in this book.

NORMAL VITAL SIGNS FOR TERM NEWBORNS:

Because it's embarrassing when the

nurse calls to tell you that the baby's RR is 65 and you can't remember what normal is.

RR 30-60 HR 100-160 SBP 50-70

FEVER

1. Make sure that baby was re-checked after taking off some of baby's clothes and placing him/her skin-to-skin for 20 minutes.
2. Are there any risk factors for sepsis (Chorioamnionitis, pre-term, prolonged ROM)?
 - a. If so, go ahead and order the standard sepsis screen (CBC, Blood Cultures, possibly a CRP) and call the peds attending to discuss starting prophylactic antibiotics.
 - b. If there aren't risk factors you can often get away with re-checking the temperature in 30 minutes. If you aren't sure, just call the Peds attending – that is what they are there for.
3. Standard Antibiotics are Ampicillin/Gentamycin
 - a. **Ampicillin** 100mg/kg q12 hours
 - b. **Gentamicin** 4 mg IV q24 hours + Gent trough before 3rd dose

HYPOTHERMIA

1. Make sure that baby was re-checked after placing him/her skin-to-skin for 20 minutes
2. Is baby still hypothermic?
 - a. Transfer the baby to the nursery to be placed in the warmer
 - b. Call the peds attending to let them know
 - c. Consider sepsis workup (get risk factors and discuss with peds attending)

TACHYPNEA (RR>60 OR E/O DISTRESS)

1. Go see the patient
2. Call the Peds attending.
3. DDX = Retained Lung Fluid (Transient Tachypnea of the Newborn or TTN),

RDS, Sepsis, Meconium Aspiration Syndrome, Hypovolemia, Acidosis, Pneumothorax, Congenital heart disease.

POLYCYTHEMIA (HIGH HEMATOCRIT)

1. Is it real?
 - a. Often hematocrits are first done with a heelstick, which can be artificially concentrated (high) if the infant's heel had to be squeezed a lot to get the blood sample.
 - b. Normal newborn Hct = 42-64%
 - c. Were there risk
 - i. Infant of diabetic mother
 - ii. Delayed cord clamping
 - iii. Dehydration (usually >48 hrs old)
 - iv. Intrauterine hypoxia 2/2 placental insufficiency – IUGR, preeclampsia, maternal smoking/cocaine/meth, maternal heart disease
 - v. Symptoms of hyperviscosity syndrome: jitteriness, plethora, irritability, emesis, poor feeding, jaundice, hypoglycemia
2. Management
 - a. Check a "central" or venous hematocrit, blood glucose.
 - b. Consider getting a serum bilirubin and calcium.
 - c. Call the peds attending.

EMESIS/ABDOMINAL DISTENSION

1. Babies do spit up
2. Bilious emesis (bright yellow or green) is always worrisome until proven otherwise. If an infant has true bilious emesis, they need urgent pediatric surgical evaluation. DO NOT WAIT.

3. Worry about ischemic bowel (AKA necrotizing enterocolitis or NEC)
 - a. Risk factors for fetal hypoxia?
 - b. Is baby's belly getting distended per a nursery RN who has been checking serially?
 - c. Has baby gotten an abdominal x-ray yet?
4. Ask yourself the simple questions like "does baby have an anus?"
5. Consider when you want to call the peds attending, before you order studies or after. Just remember that the peds attending might want to add a study to your order set, and if that study is a lab you don't want to have to stick the baby twice.

HYPOGLYCEMIA

1. General points
 - a. Hypoglycemia is a glucose of less than 40-45 in any aged infant
 - b. Symptoms of hypoglycemia include apnea, hypotonia, irritability, tachypnea, poor feeding, tremors/jitteriness, temperature instability, seizures, lethargy, tachypnea
 - c. Being born to a diabetic mother is the biggest risk factor by far.
 - d. Other causes are perinatal stress, sepsis, asphyxia, polycythemia (extra RBCs eat up more glucose), shock, IUGR/SGA infant, premature infants. There are also congenital in-born errors of metabolism and hormonal problems that can cause it but these are much more rare.
2. What to do
 - a. Has the test been repeated?
Has plasma glucose been sent to the lab?

- b. The nurses will often respond to the low glucose level by giving them breast milk or formula and then re-checking before they call you.
- c. If the blood glucose doesn't increase nicely by feeding, call the Peds attending and make a plan for oral vs. IV glucose and a likely transfer to the nursery.

OTHER NURSERY INFO:

Sepsis: Ampicillin and Gentamicin for all babies with mothers with chorioamnionitis, funny behavior, etc. If Mom is GBS + without antibiotics or GBS status is unknown, order a sepsis screen. This is a CBC-D and blood cultures. When blood cultures are negative for 48 hours then ampicillin and gentamicin may be discontinued. Do not forget to do this because they draw blood for a gentamicin level before AND after the third dose, so baby gets stuck unnecessarily if you forget.

Discharge:

- 2 day stay if vaginal birth,
- 3 days if Cesarean section
- Early d/c can happen after 24 hours for NSVD as long as baby is perfect and there are no risk factors or social issues.

POST-PARTUM CONTRACEPTION:

Vaginal intercourse should not be resumed until a few weeks postpartum, particularly with laceration repairs. Even though they all swear that they never want to have sex again after giving birth, many women will resume intercourse prior to the routine postpartum visit at 6 weeks post delivery.

Thus, all women are offered contraception at discharge. The following options are available:

DepoProvera 150 mg IM on day of discharge:

The injection will last for 12 weeks and is very effective. There are no contraindications but use caution in patients with a history of depression. The most common side effects are irregular bleeding or amenorrhea, increase in acne and a possible increase in weight (2-5 lbs). DepoProvera is thought to be safe with breastfeeding.

Combined OCPs:

Effective if taken correctly. The patient should start 2-4 weeks from delivery to avoid the thromboembolic risks in the immediate postpartum period. Breast-milk volume can decrease so she should be advised to breastfeed more frequently when starting the pill and to delay starting/use alternative contraception if she is having trouble breastfeeding. **Contraindications:** hypertension, history of DVT, thromboembolic event, migraines with neuropathic symptoms, significant liver disease, smokers over 35.

Ortho Evra Patch:

Same start times and contraindications as the combined pill.

Nuvaring:

Same start time and contraindications as the combined pill. Not covered by emergency medical, but the patient can get this through the women's clinic.

Progesterone only pill:

Norethindrone 0.35 mg each day. Not as effective as the combined preparations but works well enough in the exclusively breastfeeding woman. **NO PILL FREE WEEK.** Common side effects are spotting, irregular bleeding. Start 2 weeks post-partum.

IUD:

(Paraguard or Mirena): Can be placed at 6 weeks post-partum. Be sure to schedule an appointment for placement. Consider interval contraception. Mirena can be placed 10 minutes after delivery but will have a higher expulsion rate.

Condoms and contraceptive foam:

Prescribe 12 condoms and one package of foam

Plan B:

Emergency contraception. Give at discharge to anyone with uncertain contraception plans and recommend that they fill the prescription so that it's available when they need it. Take both pills as soon as possible after intercourse within 3-4 days.

Laparoscopic Tubal Ligation:

Can be done immediately postpartum if 30-day consent was signed far enough before delivery. Otherwise schedule for 6 weeks if signed in the hospital. If planning post-partum tubal ligation (PPTL), make the patient NPO after midnight the day before the procedure. Check on the appropriate paperwork to get the operating room reserved and ensure that the surgical team can be assembled. Often PPTL is difficult to schedule over the weekend. If to be done after discharge, have the patient scheduled to f/u in GYN clinic in 2-3 weeks. Cover the contraception gap with another method.

Diaphragm:

Not popular in our population. Can be fitted at 6 weeks post-partum.

Vasectomy:

If he does not have coverage, refer to public health or Planned Parenthood. Dr. Loeliger also does them in his Hayward clinic.

Nexplanon:

This can be placed on postpartum – though not by you if you haven't received the formal training from Merck; almost all of the senior residents have, ask them for help.

EVERY WOMAN SHOULD HAVE SOME FORM OF CONTRACEPTION WRITTEN ON HER DISCHARGE SHEET! EVEN IF IT'S JUST CONDOMS AND PLAN B!

Other OB discharge medications:

We routinely give...

Motrin 600 mg – one q6 hrs PRN cramping/pain #30

Docusate Sodium 250 mg – one BID PRN constipation #20 and for third or fourth degree lacerations

Milk of Magnesia: Give 8 ounce bottle for third or fourth degree lacerations.

FeSO₄ 325mg daily if Hgb 8-10 or BID if Hgb < 8

Vicodin Post c/s or tubal ligation. No more than 3 g acetaminophen in 24 hours (6 tablets).

Prenatal Vitamins: If the patient is out give #100 (1 PO daily)

pfannenstiel incisions are removed on the day of discharge but if wound looks like it may separate or if it's a vertical incision leave staples in and be sure patient has an appointment for staple removal.

Gestational Diabetes:

75 gram GTT at 6 weeks' Post-Partum is recommended by ACOG for all patients with GDM. However, it is important message to the patient that lifelong dietary changes/weight control can prevent diabetes and periodic screening is necessary. If she has a glucometer, recommend doing a FBS every 6 months and if it's >110 consider more formal screening.

FOLLOW-UP VISITS

NSVD/Vacuum-Assisted Delivery:

Schedule a post partum check at 6 weeks with patient's prior provider by writing it on the purple discharge for,. However, if they were seen in the prenatal clinics they will need a different provider... the appointment line should help them with this.

Cesarean Section:

Have ward clerk schedule a wound check in one week by writing it on the purple sheet. Usually staples from

Insurance Codes

Adapted from a Jan Diamond, MD

The little obscure two letter codes on your patient's cranberry card can tell you a lot about them- and what medications they can afford — if you know what they mean!

'A' BASIC ADULT: County Program for county residents with limited assets who do not qualify for Medical or Medicare. Lots of paperwork and needs to be renewed frequently- often difficult for some of our patients. Formulary the same

- AO** Basic Adult Care 'only'
- AN** Basic Adult for homeless
- AT** Basic Adult with Medical Pending
- AZ** Basic Adult pending

'M' MEDICARE: Patient older than 65 or permanently disabled. Part A covers inpatient, Part B covers outpatient, Part D covers prescription drugs. Unfortunately, there are myriad part D programs (private companies) with myriad formularies. Thankfully most common medications are covered. Your pharmacist is an invaluable resource here.

- MO** Medicare only
- MT** Medicare and Medical: "Medicare Trumps"- so the patient uses medicare part D for prescription coverage (see below).
- ML** Medicare and Mental Health Coverage
- MI** Medicare and private insurance: Most elders, though perhaps not in our system, will have a supplemental insurance program to cover things that Medicare doesn't, i.e. nursing home, etc.

'T' MEDICAL: Patient with limited assets, within a pre-defined range, not disabled or over 65 years. Has a prescription drug component which is essentially the same as Medicare Part D- Medical picks a 'Top Ten' of the Medicare Part D programs each year and offers them to clients.

- TO** MediCal only
- TP** Medical and Full Scope
- TR** Restricted Medical (pregnancy)
- TRTP** Restricted Medical and Full Scope
- TZ** MediCal Pending

'F' "FUNNY": Per MD Diamond, "Funny" CCHP plans, or a variety of Medicare supplemental programs that CCHP sells (see 'MI', above). Formulary should still be with Medicare Part D, though would check with patient. Some examples:

FY/F9 Medicare with CCHP supplemental

'H' County Health Plan: (or Private Pay if H9). Operates as a managed care organization administered and funded by the County. Also covers employees, which is easy to remember because the 'HO' is what you are all too often! Formulary updated yearly can be found at: <http://selectcare.performrx.com/pdf/formulary/formulary.pdf>. CCHP may change certain drugs more frequently, of which you will be notified in your mailbox.

- HO** CCHP only
- H9** Private Pay

'G': MEDICAL FOR FAMILIES & CHILDREN: also CCHP if less than 21 years.

- GO** Medical for families and children
- GQ** Medical for families and children plus

COUNTY CARE FOR UNDOCUMENTED PATIENTS

PK

- ★ If your patient has a financial class code 'PK' or 'PQ', that patient is **UNDOCUMENTED**.
- ★ If you have an inpatient who *needs more than 1 follow-up specialty clinic visit*, e-mail **Dr. David Goldstein** (Chief Medical Officer) and explain the circumstances
- ★ Inpatients with *diagnosed breast or cervical cancer* qualify for Medi-Cal for 18 months. Talk to **financial counseling**.
- ★ Inpatients with *life-threatening conditions* may qualify for Medi-Cal via PRUCOL (Proof of Residence Under Color of Law). Examples include renal failure requiring dialysis, persistent vegetative state, diagnosed cancer. Patients must disclose immigration status. Talk to **financial counseling**.

COMMUNITY HEALTH CENTERS

PQ

- ★ Inpatients *without specialty clinic needs* should be referred to community health centers (e.g., Brookside, La Clinica de la Raza). Do not arrange follow-up for undocumented patients within our system as they will end up lost to care.
- ★ Community Health Centers provide primary care **ONLY**. The **county pays for 3 visits per patient**, with an option to renew. Community clinics bill the county. Labs and imaging are not covered.

WOMEN'S HEALTH

- ★ All pregnant women in California regardless of residency status are granted Restricted MediCal (Code TR). TR stays in effect until the second calendar month after giving birth. This means that women may have anywhere from 4 to 8 weeks of post-partum care (e.g., if the delivery happened at the beginning of June, the patient should be covered until the end of July (~ 8 weeks). However, if the delivery occurred at the end of June, the patient will also be covered until the end of July (~ 4 weeks).
- ★ Post-partum patients who are losing insurance should be referred to a **FamilyPACT**. - County clinics in Concord, Richmond, Pittsburg, Martinez, La Clinica in Concord, Planned Parenthood are participating members. FamilyPACT provides free STD testing, Pap smears, contraception, and services that "Protect reproductive health by helping patients take care of themselves so that they can have a healthy baby when ready."
- ★ **Women must have reproductive potential to be eligible for FamilyPACT.** Post-menopausal women and women who have undergone a sterilization procedures (e.g., tubal ligation) are not eligible for FamilyPACT.

NON-EMERGENCY SURGERY

- ★ Inpatients who need non-emergency surgery should be referred to **Community Health Centers**, which can make a referral to **Operation Access**, a service that provides free non-emergency, outpatient surgeries (e.g. hernia repair, knee procedures, cataract, diagnostic colonoscopy) at John Muir and Kaiser.

MEDICATIONS

- ★ **Target and Walmart \$4 formularies** cover most common medications (not pain medications, insulin, or most psych meds)
- ★ Please be sure to discharge undocumented patients with medications **THEY CAN AFFORD**, as they are otherwise uncovered.
- ★ You can search their websites or download their formularies from Epocrates

ccLink Tips & Tricks



Shortcuts		SmartLinks	
Date Conventions		.me	Your name
t	Today	.td	Today's date
w	Week	.now	Current time
m	Month	.fname	Patient first name
+	Add Time Unit (e.g., t + 6 = 6 days later)	.id	The patient's name, age, sex
-	Subtract Time Unit (e.g., w - 3 = 3 weeks ago)	.age	Patient age
Navigator Shortcuts		.dol	Day of Life
F7	Open previous Navigator Section	.sex	Patient sex
F8	Open next Navigator Section	.bmi	Body Mass Index
F9	Open/Close current Navigator Section	.cc	Chief Complaint
Alt + F7/F8	Move up through Navigator table of contents. Release ALT to open section	.admitdx	Admission Diagnosis
Shift + F7/F8	Move to previous/next Navigator Section without opening it	.hxpmmh	Past Medical History
ccLink Shortcuts		.hxpsch	Past Surgical History
F2	Move to next SmartText in document	.hxfamily	Past Family History
'.' + Text	Insert SmartText	.cmed	Current med list
CTRL + Left Click	Select Non-consecutive items in SmartList	.algp	Allergies in prose
CTRL + Left Click	Select Consecutive items in SmartList	.ipvitals[x]	Last 'x' hours of vitals in tab format
CTRL + P	Print	.v	Last vitals in paragraph format
CTRL + Alt + S	Secure Workstation	.iobrief	I/O totals for past 24 hours
CTRL + Alt + L	Log out of ccLink	.labrcnt[x]	Most recent lab of type 'x'
			Specify last # of draws of 'x' components of lab (e.g., last 3 Na,Cr y:#,z:#, etc. = .lastlab[Na:3, Cr:3])
		.labs24	Labs in past 24 hours
		.thisvisit	Most recent results from this visit

Sidebar: To keep desired information in view while perusing the rest of the chart (e.g., compare past and present echo reports), right click the item of interest and choose "Display in Chart Sidebar"

The screenshot shows the ccLink software interface. The patient is Peacockgoat, Thelma. The chart review section shows a list of medications. A red box highlights the 'Display in Chart Sidebar' option in the right-click context menu for a medication entry. The sidebar on the right shows the selected medication: morphine (MS CONTIN) 30 MG tablet [20921].

Sliding Scales

P o t a s s i u m

Serum K ⁺	KCl (mEq) to give IV or PO
3.7 — 3.8	20
3.5 — 3.6	40
3.3 — 3.4	60
3.1 — 3.2	80
≤ 3.0	100

N i t r o p a s t e

Systolic BP	Action
< 100	Wipe Off
100 - 120	1"
121 - 140	2"
> 140	3"

M a g n e s i u m

Serum Mg ²⁺	MgSO ₄ (g) to give IV
1.8 — 1.9	1
1.6 — 1.7	2
1.4 — 1.5	3
1.2 — 1.3	4
< 1.2	5

P h o s p h a t e

Serum P (mg/dL)	Action
2.7 — 4.5	None
2.1 — 2.4	None or PO repletion
1.0 — 2.0	5 - 10 mmol IV
< 1.0	10 - 20 mmol IV

*“A merry heart doeth good
like medicine.”*

—King Solomon

This book belongs to

If found, please

Page (925) 346-4_____

or

Leave at nearest Nurses' Station

Thank you!